East Suffolk and North Essex
NHS Foundation Trust

Financial Framework 20/21

Focus on M1-M4 revenue requirements

Financial context : national COVID-19 guidance (revenue)

At a glance

Operational planning has been suspended until further notice.

To simplify processes and reduce the number of transactions during the COVID-19 outbreak some temporary changes (April to July 20) have been introduced.

These include moving to a nationally determined monthly 'block contract' payment and where necessary 'top-up' payment designed to cover costs.

The methodology adopted effectively means providers will be funded for the level of expenditure (uplifted for inflation) seen on average between November 2019 and January 2020

Operational Planning and Budgets

Operational planning has been suspended by NHSI until further notice.

Temporary arrangements 1st April to 31st July

All NHS providers are being guaranteed a minimum level of income reflecting their current cost base, together with the ability to claim for additional costs where these reflect 'genuine and reasonable additional marginal costs due to COVID-19'. Consequently, the expectation is that this will ensure adequate funds for providers to deliver a **break-even revenue position** during the period, and indeed this will inform the basis of NHSI/E's monitoring of performance during this time.

Detailed guidance provided by NHSI/E confirms this approach:

1) All NHS Trusts and Foundation Trusts ('providers') will move to block contract payments 'on account' for an initial period of 1 April to 31 July 2020, with **suspension of the usual PBR national tariff payment architecture** and associated administrative/ transactional processes

2) A **national top-up payment** ('projected top-up') will be issued to providers to **reflect the difference between the expected baseline net costs and block contract and other income**, where modelling of the expected cost base is higher.

3) A national true-up ('retrospective true-up') will be provided to adjust provider positions for additional costs and/or loss of revenue where the block and top-up payments do not equal the actual costs of genuine and reasonable additional marginal costs due to COVID-19.

(4) Providers should **continue with provider to provider invoicing** in line with normal billing arrangements to reflect services actually provided, but should proceed in the spirit of the interim financial framework, simplifying where possible and paying invoices promptly.

5) These funding streams should provide sufficient funds for providers to deliver a break-even position through the period and will provide the basis against which we will monitor financial performance.

What does this mean for providers funding?

While the temporary arrangements remain in place, providers will effectively be funded at their (inflationary adjusted) average actual expenditure run rate seen between November 2019 and January 2020. This has been confirmed in the guidance outlining the national top-up payment calculation:

-Calculate the average actual expenditure incurred between months 8 to 10 in 2019/20.

-Uplift this monthly average for inflation (values used are consistent with existing plan assumptions) to derive an expenditure 'requirement'.

-Compare this expenditure 'requirement' to the block contract value previously notified.

-Receive any shortfall between the 'required' expenditure and the block income as a monthly top-up payment.

Further 'reasonable' costs incurred as a result of CoVID-19 will be funded by a further payment.

Financial context : national COVID-19 guidance

At a glance

Maintenance of financial control remains critical during the NHS response to COVID-19.

All NHS providers and commissioners must carefully record the costs (revenue and capital) incurred in responding to the outbreak, and will be required to report actual costs incurred on a monthly basis.

PDC charges will not be incurred for COVID-19 capital spend.

Monthly reporting to NHSI/E for April to July will be completed on a smaller basis relative to 19/20 returns, with the focus on the capture of COVID-19 costs.

Financial Governance

NHSI/E stress that the maintenance of financial control and stewardship of public funds remains critical during the NHS response to COVID-19. Chief Executives, Accountable Officers and Boards must continue to comply with their legal responsibilities and have regard to their duties as set out in Managing Public Money and other related guidance. Any financial mismanagement during this period will be dealt with in exactly the same way as at any other time

As normal financial arrangements have been suspended, no new revenue business investments should be entered into unless related to COVID-19 or unless approved by NHSE/I as consistent with a previously agreed plan.

Normal consultancy approval and agency reporting requirements must be maintained during this period.

COVID costs - revenue

Reasonable additional marginal costs due to COVID-19 that providers should claim for include:

a) Evidenced increases in staffing costs compared to the baseline period associated with dealing with increased total activity.

b) Increases in temporary staffing to cover increased levels of sickness absence or to deal with other caring responsibilities (e.g. to look after other family members).

c) Payments for bank or sub-contractor staff to ensure all sickness absence is covered consistent with Government's announced policy and public health advice which aren't otherwise covered under normal practice; and

d) Additional costs of dealing with COVID-19 activity. For example:

-the costs of running NHS 111 assessment pods

-increases in the volumes required or prices of equipment to deal with the response to the virus which aren't offset;
-extra costs of decontamination and transport for the ambulance service;
-higher testing volumes in acute-based laboratories;
-community-based swabbing services.

COVID costs – capital

For providers to access capital in relation to the COVID-19 response they need to demonstrate:

a) The proposed expenditure must be clearly linked to delivery of the COVID-19 response;
b) In the case of asset purchases, the asset must be capable of being delivered within the expected duration of the outbreak; and
c) In the case of modifications to estate, the works must be capable of being completed within the expected duration of the outbreak

PDC charges will not be levied on any funding supplied in connection with COVID 19

Reporting

NHSI/E have advised that the monthly finance returns for April to July will be smaller than the full monthly returns used in 2019/20. They will comprise a SOCI together with supporting schedules, as well as some limited SOFP and cash flow data.

The key focus of collections during this time will be to inform the retrospective top up payment.

An additional tab will collect the element of year to date expenditure that relates to COVID-19.

Financial context : revenue plan for M1 to M4 notified by NHSI/E

At a glance

Providers are to deliver a breakeven revenue position for April to July.

NHSI/E have modelled an expected level of spend (not including COVID-19 costs) for this period, and will provide an equivalent level of funding (not including other operating income).

These plans have been shared by NHSI/E and will be used as the basis for monitoring provider performance during this time.

Whilst the temporary arrangements remain in place, ESNEFT will be funded at the (inflationary adjusted) average actual expenditure run rate seen between November 2019 and January 2020. In mid-April, as part of top-up payment guidance and calculation for the Trust, a summary was shared by NHSI/E of the baseline that had been used, with any relevant adjustments, applied growth assumptions, and the resultant calculated top-up value. This is summarised below:

20/21 ESNEFT financial plan for COVID-19 pandemic period as advised by NHSI/E - April 20 to July 20

	TRUST 19/20 AVERAGES BASED ON M10 PFR						TRUST 20/21 PLAN AS ADVISED BY NHSI/E			
	2019/20 M8	2019/20 M9	2019/20 M10	Average 3 Months	Adj	Baseline	April M1	May M2	June M3	July M4
Total Income From Patient Care Activities	54,008	53,377	56,441	54,609	0	53,997	55,476	55,476	55,476	55,476
Total Other Operating Income	5,005	4,731	5,269	5,002	0	4,513	4,513	4,513	4,513	4,513
Total Operating Income	**59,013**	**58,108**	**61,710**	**59,610**	**0**	**58,510**	**59,989**	**59,989**	**59,989**	**59,989**
Total Employee Expenses	(36,767)	(37,173)	(37,626)	(37,189)	0	(37,189)	(38,058)	(38,058)	(38,058)	(38,058)
Total Operating Expenditure excluding Employee Expenditure	(26,324)	(24,812)	(25,435)	(25,524)	0	(25,512)	(25,880)	(25,880)	(25,880)	(25,880)
Total Operating Expenditure	**(63,091)**	**(61,985)**	**(63,061)**	**(62,712)**	**0**	**(62,701)**	**(63,938)**	**(63,938)**	**(63,938)**	**(63,938)**
Operating surplus / deficit	**(4,078)**	**(3,877)**	**(1,351)**	**(3,102)**	**0**	**(4,191)**	**(3,949)**	**(3,949)**	**(3,949)**	**(3,949)**
Net Finance Costs	(533)	(551)	(606)	(563)	0	(563)	(832)	(832)	(832)	(832)
Surplus / (deficit) for the period	**(4,609)**	**(4,418)**	**(1,951)**	**(3,659)**	**0**	**(4,754)**	**(4,781)**	**(4,781)**	**(4,781)**	**(4,781)**
Top-Up Income							**4,781**	**4,781**	**4,781**	**4,781**

As well as confirming an anticipated monthly spend of £64.77m (not including COVID-19 expenditure), and funding to match this (a block value of £55.476m, and top-up of £4.781m are both 'guaranteed' for each month, whilst other operating income, which includes provider to provider funding, is variable and is 'expected' to equal c.£4.5m) this is the revenue plan against which NHSI/E will monitor the Trust's financial performance.

Financial context : internal revenue budget considerations for M1-M4

At a glance

Delivery of divisional control totals is vital to ensure the Trust can achieve a breakeven positon between April and July.

Remaining divisional budget gaps present a risk to this.

The only adjustments to divisional plans relate to the RES contract with the Oaks and car parking income.

CIP targets are expected to still be delivered by each division.

Control totals and governance

Budgets are being uploaded to the Trust's ledger in line with the latest submissions in March. There are remaining budget gaps in divisions which will need to be closed. Divisions are expected to meet their Control Totals.

An assessment has been made of the impact on both the Trust's income (not covered by central funding) and expenditure during the COVID-19 response. With the exception of the Oaks routine elective services contract, and car parking income where material impacts are anticipated and these budgets are to be vired to non-divisional areas, other budgets will remain unaffected but will need to be managed carefully given the scale of the financial challenges in 2020/21.

The Board has agreed the proposed governance arrangements; and these are now in place for all divisions. The additional governance for COVID expenditure will continue. Accountability arrangements remain as per the Accountability Framework which has not changed (though Divisional Accountability Meetings are suspended for April, May and June).

CIP

It is acknowledged that some CIP schemes may have slipped because of COVID-19, but equally there has been significant investment and transformation in a short period which will facilitate new CIP schemes. Savings made in months 1-4 retained within the division should be managed carefully to improve the overall financial position for the division. The CIP target for each division remains the same and is expected to be met.

Other considerations

Central funding arrangements between April and July mitigate much of the risk from reduced activity, though lower levels of other operating income (such as provider to provider activity and private patients) will be problematic.

Expenditure needs to be tightly controlled, including that related to COVID-19, and value for money maximised to secure the best possible position post July. Expenditure requests for COVID-19 should be made prospectively, not retrospectively and divisions should not expect others to do this on their behalf e.g. sickness cover.

Financial context : internal M1-4 revenue budgets by division

The divisional budgets for M1 to M4 (April to July), and the control totals to be achieved for this period are detailed on this slide.

Adjustments have been actioned for:

-RES Contract budgets on non-pay for MSK, Surgery and Women's and Children's have been moved to Non-Divisional. Total value of £2.779m across the three divisions based on the suspension of this activity for the whole period.

-Car parking income of £1m vired from Corporate income to Non-divisional.

-Logistics budgets mapped to new divisions based on new governance arrangements for departments.

Please note that full CIP targets have been retained in these budgets.

£s

Division	Category	M1 April	M2 May	M3 June	M4 July	April to July (Total)
Central Income	Income	(55,941,836)	(55,941,836)	(55,962,836)	(55,962,836)	(223,809,343)
Central Income Total		**(55,941,836)**	**(55,941,836)**	**(55,962,836)**	**(55,962,836)**	**(223,809,343)**
Cancer_and_Diagnostics	Income	(531,439)	(531,452)	(553,108)	(553,115)	(2,169,114)
	Pay	5,886,425	5,877,348	5,865,766	5,868,703	23,498,242
	Non Pay	6,180,054	6,134,868	6,156,037	6,035,131	24,506,090
Cancer_and_Diagnostics Total		**11,535,040**	**11,480,764**	**11,468,695**	**11,350,719**	**45,835,218**
Capital_Charges	Income	(15,250)	(15,250)	(15,250)	(15,250)	(61,000)
	Non Pay	2,320,116	2,320,116	2,308,535	2,302,547	9,251,314
Capital_Charges Total		**2,304,866**	**2,304,866**	**2,293,285**	**2,287,297**	**9,190,314**
Corporate_Services	Income	(1,713,681)	(1,713,677)	(1,713,684)	(1,713,679)	(6,854,721)
	Pay	5,546,795	5,549,390	5,552,050	5,564,341	22,212,576
	Non Pay	4,887,085	4,884,552	4,848,496	4,981,920	19,602,053
Corporate_Services Total		**8,720,199**	**8,720,265**	**8,686,862**	**8,832,582**	**34,959,908**
Integrated_Pathways	Income	(113,566)	(113,569)	(113,569)	(113,569)	(454,273)
	Pay	4,345,191	4,346,226	4,346,731	4,347,045	17,385,193
	Non Pay	1,834,204	1,835,218	1,836,099	1,836,650	7,342,171
Integrated_Pathways Total		**6,065,829**	**6,067,875**	**6,069,261**	**6,070,126**	**24,273,091**
Medicine_Colchester	Income	(207,833)	(207,831)	(207,834)	(207,826)	(831,324)
	Pay	3,743,436	3,735,334	3,734,248	3,736,352	14,949,370
	Non Pay	995,861	996,037	996,072	996,091	3,984,061
Medicine_Colchester Total		**4,531,464**	**4,523,540**	**4,522,486**	**4,524,617**	**18,102,107**
Medicine_Ipswich	Income	(45,254)	(45,258)	(45,271)	(45,263)	(181,046)
	Pay	3,764,963	3,757,660	3,765,162	3,765,162	15,052,947
	Non Pay	929,446	930,863	930,854	930,850	3,722,013
Medicine_Ipswich Total		**4,649,155**	**4,643,265**	**4,650,745**	**4,650,749**	**18,593,914**
MSK_and_Specialist_Surgery	Income	(148,076)	(148,080)	(148,081)	(148,075)	(592,312)
	Pay	3,815,864	3,818,854	3,820,735	3,825,183	15,280,636
	Non Pay	2,681,519	2,681,849	2,681,885	2,681,588	10,726,841
MSK_and_Specialist_Surgery Total		**6,349,307**	**6,352,623**	**6,354,539**	**6,358,696**	**25,415,165**
Non_Divisional	Income	(265,625)	(265,625)	(265,625)	(265,625)	(1,062,500)
	Pay	195,557	195,557	195,557	195,557	782,228
	Non Pay	4,038,316	4,097,239	4,163,051	4,131,679	16,430,285
Non_Divisional Total		**3,968,248**	**4,027,171**	**4,092,983**	**4,061,611**	**16,150,013**
Surgery_and_Anaesthetics	Income	(163,443)	(163,442)	(163,447)	(163,440)	(653,772)
	Pay	6,842,832	6,844,680	6,845,658	6,847,254	27,380,424
	Non Pay	1,525,165	1,525,332	1,525,413	1,525,243	6,101,153
Surgery_and_Anaesthetics Total		**8,204,554**	**8,206,570**	**8,207,624**	**8,209,057**	**32,827,805**
Womens_and_Childrens	Income	(113,229)	(113,226)	(113,228)	(113,227)	(452,910)
	Pay	4,186,288	4,187,919	4,189,373	4,190,380	16,753,960
	Non Pay	321,115	321,204	321,211	321,229	1,284,759
Womens_and_Childrens Total		**4,394,174**	**4,395,897**	**4,397,356**	**4,398,382**	**17,585,809**
Grand Total - (Surplus) / Deficit		**4,781,000**	**4,781,000**	**4,781,000**	**4,781,000**	**19,124,000**
Top Up Income		(4,781,000)	(4,781,000)	(4,781,000)	(4,781,000)	(19,124,000)

Financial arrangements beyond July 2020 (revenue)

At a glance

Financial arrangements after July 20 are to be confirmed.

The notified Financial Improvement Trajectory (FIT) for the Trust for 20/21 was a deficit of £34.1m deficit.

It was confirmed that deficits would be fully funded through Financial Recovery Fund (FRF) allocations for those organisations that met their FIT.

How much of the financial regime will operate in future years; and how and when we transition away from the exceptional arrangements operating between April and July 20 is not yet known or confirmed by NHSI/E (changes to the NHS Capital and Cash Regimes, effective from 1 April 2020, have been published by DHSC– see below and next slide).

It is nonetheless useful to recap the key points of 20/21 operational planning before it was suspended, in the expectation that elements of this will be expected to be achieved:

- DHSC's long term requirements, to be addressed in both system and organisational plans (5 Financial Tests), are:

* meet its trajectory for 2020/21 and the following three years
* achieve cash-releasing productivity growth of at least 1.1% each year
* reduce the growth in demand for care via integration and prevention
* reduce unwarranted variation in performance
* make better use of capital investment and existing assets.

- The Trust was notified in February of a change to its financial improvement trajectory (FIT, formerly known as control total) for 2020-21 (from £31.9m deficit to £34.1m deficit) primarily to address planned changes in the financing regime (debt regime and the impact of National Tariff impact assessments).

- Updated Financial Recovery Fund (FRF) allocations were also confirmed reflecting the decision by NHSI/E to fully fund deficits through FRF for organisations meeting their financial improvement trajectories, simplifying financing arrangements for providers.

As part of the guidance to *Reforms to the NHS Cash Regime effective from 1 April 2020,* this expectation that 'breakeven' will be achieved is reiterated as DHSC state:

Once the system returns to business as usual providers will be expected to deliver a breakeven or surplus position. Providers currently in deficit will be expected to reach balance or agree an achievable financial improvement trajectory with NHSEI to make reasonable progress towards this goal before the start of each financial year. This is temporarily suspended for the duration of the COVID-19 response but will be re-established once the threat has passed

Cash and Capital regimes : key changes from 1st April

At a glance

New national cash and capital regimes from 1 April 2020

Key changes:

- All outstanding interim support loans (revenue and capital) to be converted to Public Dividend Capital (PDC).
- Cost of borrowing on loans replaced by dividend payable on PDC.
- Capital funding to be allocated to ICS.

DHSC wrote to providers on 2nd April (and as announced by the Health Secretary) to outline the new cash and capital regimes that will be effective as of 1 April 2020.

The aim of these changes is to allow for more consistent financial planning and free providers up to invest in maintaining vital services and capital requirements.

Key Changes

- New Public Dividend Capital (PDC) issued "to repay over £13.4 billion of the NHS' historic debt, in effect writing it off".
- A move away from interest-bearing loans for future interim capital and revenue support, which instead will be provided as PDC.
- Providing a capital spending envelope for the year to every local area, within which each STP / ICS will be expected to work together to manage their spending.

Adjustments will be made to top-up payments / financial improvement trajectories to take account of the net cost or net benefit to each organisation of the replacement of loans with PDC. For ESNEFT this represents a cost, the dividend payable at 3.5% on PDC is greater than the interest charges on its current borrowing.

Revenue support will be provided as PDC which does not require principal repayment but carries a dividend payable at the current PDC rate. This reflects the opportunity cost to the taxpayer of diverting finance to unplanned cash requirements.

Writing off historic debt – the process

Interim revenue loans, including working capital facilities and interim capital debt at 31 March 2020 are to be extinguished during FY20/21.

Providers will be issued Public Dividend Capital (PDC) to effect the repayment of outstanding balances at 31 March 2020. This excludes capital normal course of business (NCB) loans.

All loans will be frozen at 31 March 2020 and interest payments will cease from that date.

PDC in the equivalent amount will be issued to providers alongside an MoU to repay the loans on 30 September 2020.

It is not expected that any adjustment to balance sheets at 31 March 2020 or opening balances as a result of this change

The national top-up payment for COVID-19 arrangements during the outbreak and allocation of FRF income once business as usual is restored will be adjusted so the revenue impact of the debt write off does not create a revenue gain or loss.

Cash regime : Future revenue and capital support

At a glance

Future revenue support will be available as PDC.

PDC dividend rate is to be reviewed by DHSC and NHSI/E.

Emergency capital allocations will be available in appropriate circumstances.

Capital loans from DHSC will also be available exceptionally.

Future revenue support

Future revenue support will be available for exceptional short-term cash flow requirements, and longer-term revenue support for providers in financial distress.

This support will be provided as PDC. Although this does not require principal repayment, it carries a dividend payable at the current PDC rate (currently 3.5%). This reflects the opportunity cost to the taxpayer of diverting finance to unplanned cash requirements.

The dividend will apply for at least one year from the date the revenue support is drawn, and will cease after one year (if a provider is and remains in surplus), or once a provider succeeds in reaching breakeven or surplus and no longer requires additional financial support (if a provider is currently in deficit).

DHSC and NHSI/E will carry out a review of the PDC dividend rate as it applies across the NHS financial architecture in the financial year 20/21. This review will consider the impact of lowering the PDC rate against the benefits of doing so with the intention of making any appropriate changes for financial year 21/22.

Future capital support

The capital regime will move to affordable capital envelopes being allocated to STP/ICS for local prioritization of system driven operational capital expenditure.

It is expected that this will mainly be self-financed from the depreciation element of tariff, and self-financed cash balances.

An element of discretionary capital will be allocated to each system for the purpose of dealing with the most pressing maintenance needs for trusts that are cash constrained.

An emergency capital allocation will be available for applications that meet the criteria. Applications must demonstrate urgent and essential capital expenditure that has been prioritized by their STP/ICS and NHSI/E regional team but are unaffordable to individual organizations. Where accepted, applications will receive PDC. This is a temporary measure intended to be phased out over a number of years as the sector returns to financial balance.

There remains the possibility for providers to receive a capital loan from DHSC. However, this facility will be by exception and the provider must demonstrate that it is clearly affordable within the ICS/STP envelope through guaranteed underspends from other providers across the area.

COVID-19 arrangements

Revenue: DHSC revenue support should not be needed during this period but will be available as a safety net, should it be required

Capital: PDC will be issued to providers for all genuinely additional capital expenditure driven directly by the COVID-19 response and this will be on top of affordable capital envelopes. No PDC dividend will be payable on PDC issued for this expenditure in FY19/20 and FY20/21

Capital regime : overview

At a glance

Capital allocations to ICS / STP for prioritization.

No requirement to resubmit plan whilst COVID-19 underway.

Provider allocation of £5.8bn split into 3 categories:

1) System level allocation;
2) Nationally allocated funds;
3) Other national capital investment.

The allocation of a capital envelope for each STP / ICS is intended to:

-provide greater clarity and confidence on the level of capital resource available,
-support system working and discussion on capital priorities;
-enable faster access to national capital funding for critical safety issues.

However, while the COVID-19 response is underway, DHSC do not expect organisations to resubmit capital plans, given the likelihood that the pandemic will have a material impact on capital plans, priorities and levels of expenditure.

Capital requirements agreed as part of COVID-19 costs will be funded on top of the allocations that have been announced (detailed below).

NHS operational capital funding

NHS provider capital allocation for 20/21 has been set at £5.8 billion, and will be split into three categories:

1. A system-level allocation (£3.7bn) – to cover day-to-day operational investments (which have typically been self-financed by organisations in the ICS/STP or financed by DHSC through emergency loans).

2. Nationally allocated funds (£1.5bn) – to cover nationally strategic projects already announced and in development and/or construction such as hospital upgrades, diagnostics machines, and new hospitals.

3. Other national capital investment (£0.8bn) – including national technology capital provided by NHSX. Elements of this may be subsequently added into system-level or national level allocations during the financial year.

Capital regime : system level allocation and funding sources

At a glance

ICS/STP capital allocations are still to be notified.

Providers remain legally responsible for maintaining estates and delivering organizational capital investment plans.

Every ICS/STP is accountable for spending within overall capital budget.

Expectation that the majority of system-level expenditure will be self-financed by providers, through depreciation or other sources of locally held cash.

IFRS16 implementation has been delayed for a year for the NHS.

Capital allocations from 2020/21

Every ICS/STP will receive a 2020/21 capital spending envelope (to be notified shortly, including the underlying methodology to allocate capital) derived from the system-level allocation.

While providers remain legally responsible for maintaining their estates and for setting and delivering their organisational level capital investment plans, every ICS/STP will have to account for ensuring overall capital spending across their system remains within these budgets.

Organisational plans and the deployment of discretionary emergency capital will ultimately need to be consistent with these budgets and reflect system-wide discussions on prioritisation.

This supports the move to system planning, and the development of ICSs covering the country by April 2021, as part of the NHS Long Term Plan.

DHSC expect that the majority of system-level expenditure will be self-financed by providers, through depreciation or other sources of locally held cash.

Emergency capital investments

Where a provider does not have sufficient cash to support emergency capital investments that have been prioritised within the ICS/STP affordable capital envelope, providers will be able to apply to NHSI/E and DHSC for finance to be provided as PDC, replacing the current system of emergency capital loans.

DHSC capital loans

A DHSC loan facility may be available where it can be demonstrated that the investment has been prioritised within the affordable STP/ICS allocation and is affordable to the provider by way of loan principal and interest repayment.

Capital proceeds

For 2020/21, capital proceeds will be available to the system to invest in line with the system estates strategy in the year of disposal and the two subsequent years in addition to the system-level allocations.

Existing rules regarding profits on disposal not counting towards revenue control totals continue.

Charitable sources

In line with government budgeting rules, and in the year funding is received, capital receipts from external charitable sources will provide additional spending power above the issued ICS/STP capital envelope.

Loans and leases

However, all expenditure financed through loan/finance lease funding from external sources (including commercial borrowing and private finance) counts as a capital resource charge and will therefore score against the STP/ICS capital envelope in the normal way.

The implementation of IFRS16 for the NHS has been delayed until 1 April 2021.

Capital regime : reporting and monitoring

At a glance

No resubmission of capital plans is required while COVID-19 response is underway.

BUT every ICS/ STP must spend within its envelope, and if this is not achieved it will affect future year's envelopes.

Organisations are not expected to resubmit their capital plans during the COVID-19 response since this is anticipated to have a material impact on capital plans, priorities and levels of expenditure.

However, every STP/ICS is expected to spend within their envelope, and DH will monitor performance against the ICS/STP capital envelopes in 2020/21.

Capital requirements agreed as part of COVID-19 costs will be funded on top of these envelopes.

DHSC will provide each STP/ICS with regular information to support local monitoring and decision making. It is important that providers and systems provide regular, realistic and central forecasts for capital expenditure in year in order to support this, on a more robust basis than has been the case in the recent past.

Where in-year reporting indicates a potential overspend, then ICS/STPs will be expected to agree local actions to address potential overspends, supported by their regional teams.

Spending in excess of the allocated envelope will be taken into account when calculating future years' capital spending envelopes for relevant ICS/STPs as well as the way that the system overall is controlled and monitored.